

**Authorization for Release/Exchange of Information**

This form provides your therapist with written permission to communicate with other individual providers regarding your treatment (e.g. previous treating therapist, current health care providers, parents or school)

Client Name(s): _____

Client Date of Birth: _____

Release of information from Trisha Cupero, LCSW (One Breath Counseling, PLLC) to Another Person or Party Listed Below.

I authorize my Therapist to release/exchange the following information to:

Name: _____

Number: _____

Email address: _____

Address: _____

Information to be released: (Please Check)

_____ Screening Information

_____ Behavioral and Psychological Reports

_____ Treatment Plan

_____ Counseling Notes

_____ Coordination of Care

_____ Intake and History

_____ Other: _____

This release will be valid until the termination of treatment or authorization from client is revoked.

Expiration date: _____

This authorization may be revoked at any time.

Name of Patient, Client, or Authorized person (print):

Signature of Patient, Client, or Authorized person:

_____ Date: _____